TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Pain and Recovery Clinic - North

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-16-1134-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
December 30, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We feel that our facility should be paid according to the fee schedule guidelines. We are a CARF accredited facility and should not be subject to the twenty percent fee schedule reduction."

Amount in Dispute: $162.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor complains it should have been paid for its CARF accreditation but was not. Well, Texas Mutual received a bill without the CA modifier…

With the request for reconsideration Texas Mutual found no bill."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 8, 2015	Chronic Pain Management	$162.50	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for division-specific services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - CAC-P12 – Workers' Compensation jurisdictional fee schedule adjustment.
   - 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline.

- CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 891 – No additional payment after reconsideration.

Issues

1. What is the maximum allowable reimbursement (MAR) for the disputed services?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor argues that they "are a CARF accredited facility and should not be subject to the twenty percent fee schedule reduction." 28 Texas Administrative Code §134.204(h) states, in relevant part,

   > The following shall be applied to Return To Work Rehabilitation Programs for billing and reimbursement of … Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs…
   > (1) Accreditation by the CARF is recommended, but not required.
   > (A) If the program is CARF accredited, modifier "CA" shall follow the appropriate program modifier as designated for the specific programs listed below. The hourly reimbursement for a CARF accredited program shall be 100 percent of the MAR.
   > (B) If the program is not CARF accredited, the only modifier required is the appropriate program modifier. The hourly reimbursement for a non-CARF accredited program shall be 80 percent of the MAR.

   In addition, 28 Texas Administrative Code §134.204(h)(5) states,

   > The following shall be applied for billing and reimbursement of Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs.
   > (A) Program shall be billed and reimbursed using CPT Code 97799 with modifier "CP" for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited Programs shall add "CA" as a second modifier.
   > (B) Reimbursement shall be $125 per hour. Units of less than one hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes.

   Submitted documentation includes a Health Insurance Claim Form (Form 1500) with billed procedure code 97799-CP-CA. However, the insurance carrier argues that the only bill received for the disputed services did not include the CA modifier. The insurance carrier provided a Form 1500 date-stamped May 15, 2015 for billed services 97799-CP. Review of the submitted documentation does not support that a bill for 97799-CP-CA was submitted to the insurance carrier.

   The requestor is seeking additional reimbursement for 6.5 hours of chronic pain management. This is calculated as follows:

   6.5 x $125.00 = $812.50 x 80% = $650.00

2. The total MAR for the disputed services is $650.00. The insurance carrier paid $650.00. No further reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	Laurie Garnes	January 20, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.